

# INTRODUCTION - PATIENT INFORMATION

Today's Date: \_\_\_\_\_

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## PATIENT INFORMATION

**Name:** (Last, First MI) \_\_\_\_\_ **Preferred Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Home:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_ **Mobile Carrier:** AT&T Verizon Sprint T-Mobile Other \_\_\_\_\_  
**Work:** \_\_\_\_\_ **Email:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Social Security #:** \_\_\_\_\_ **Gender:** M F **Marital Status:** Married Single Other  
**Student Status:** Full Time Part Time Non-Student **Spouse Name:** \_\_\_\_\_ **# of Kids:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Are you:** Police Fire EMS Military/Vet Full time clergy  
**How did you hear about our office?** \_\_\_\_\_

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## EMERGENCY CONTACT INFORMATION

**Full Name:** \_\_\_\_\_ **Primary Care Physician:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_ **Doctor's Phone:** \_\_\_\_\_  
**Relationship:** Child Parent Spouse Other: \_\_\_\_\_

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## FINANCIAL INFORMATION

Insurance Worker's Comp Self-Pay (Cash) Personal Injury/Auto Other (please explain): \_\_\_\_\_

### PRIMARY HEALTH INSURANCE

**Insurance Name:** \_\_\_\_\_  
**Relation to Insured:** Self Spouse Parent Child Other  
*If Other than Self:*  
**Insured's Name:** \_\_\_\_\_ **Gender:** M F  
**Phone:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

### SECONDARY HEALTH INSURANCE

**Insurance Name:** \_\_\_\_\_  
**Relation to Insured:** Self Spouse Parent Child Other  
*If Other than Self:*  
**Insured's Name:** \_\_\_\_\_ **Gender:** M F  
**Phone:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Who is responsible for payment?** Self / Other - (*Relationship*) \_\_\_\_\_

*If Other than Self:*

**Full Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

### For the CURRENT condition, have you:

- **Received any other treatment?** None DC MD PT Massage ER Other: \_\_\_\_\_
  - **If yes - Where?** \_\_\_\_\_
- **Had any previous Surgery or Interventions in this area?** (*Describe*) \_\_\_\_\_
- **Taken any Medications?** \_\_\_\_\_
- **Had any diagnostic testing?** X-rays MRI CT Other: \_\_\_\_\_
  - **If yes - When and Where?** \_\_\_\_\_
- **Describe any Other Complaints:** \_\_\_\_\_

# Consents

**Consent to Bill/Collect Insurance:** I consent, if I am using a third party for payment of my services (health insurance, auto accident insurance, worker's compensation insurance, Parent/Guardian, etc), to allow Thrive Chiropractic Group to submit all necessary information needed to receive payment for the services I received to these third parties. I further consent to accept assignment of payments from my insurance company to be paid directly to the clinic or doctor. I also consent to allow Thrive Chiropractic Group to retrieve my insurance benefits. If my case is an auto accident, this would include coverage amounts for the accident as well as medpay/UIM coverage and/or canceled checks proving payment was provided.

**Consent to Examination and Treatment:** I give the doctors and staff of Thrive Chiropractic Group permission to perform all examinations, x-rays, and treatment deemed necessary by the doctor. I understand that some of these procedures may be performed by either the staff or the doctor.

**Consent to Retrieve Medical Records:** I give the doctors and staff of Thrive Chiropractic Group permission to obtain any and all medical records from other providers, offices or hospitals which may assist with my care.

**HIPAA:** A copy of the full Health Information Privacy Policy for our clinic can be requested at our front desk. In brief, it states that we will not give any information about you except as consented to above. The only people we give information to are parents/guardians if you are a minor or whomever is responsible for your bill (i.e. insurance company, third party, or attorney if you have one).

**Clinical Summary Report (CCR):** I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Thrive Chiropractic Group to save these electronically for me and not print them out after each visit. I understand that, upon written request, these reports are available to be printed or emailed to me for review.

By signing below, I consent to the above for Thrive Chiropractic Group.

\_\_\_\_\_  
Patient/Guardian Name (Print)

\_\_\_\_\_  
Patient/Guardian (Sign)

\_\_\_\_\_  
Date

**Public Display of Reviews:** I understand that if I leave a text or video review for Thrive Chiropractic Group that they may display this review online in a public forum. I give permission for Thrive Chiropractic Group to utilize my picture, video, or text review in their digital and online marketing campaign.

\_\_\_\_\_  
Patient/Guardian Name (Print)

\_\_\_\_\_  
Patient/Guardian (Sign)

\_\_\_\_\_  
Date

**Pregnancy Waiver (Women Only):** By my signature below, I am stating that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time.

\_\_\_\_\_  
Patient/Guardian Name (Print)

\_\_\_\_\_  
Patient/Guardian (Sign)

\_\_\_\_\_  
Date

# Thrive Chiropractic Group - Health Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. Many patients are referred to our office by a family member, friend or co-worker. Who or what made you decide to visit our office?  
\_\_\_\_\_

2. Science tells us your spine, like your teeth, needs to be cared for regularly.

How often do you get adjusted by a chiropractor? Frequently \_\_\_\_\_ times per month Only when I hurt Never

3. When was your last complete spinal examination including x-rays? \_\_\_\_\_ Never

4. Do you know if you have: spinal curvature spinal arthritis Family history of spinal problems

5. Over time spinal misalignments will cause arthritis and degeneration which results in a loss of nerve health and often grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move? Yes No

6. If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back. Do you often feel the need to crack or pop your neck, mid-back or lower back? Yes No

7. Poor posture has been shown to lead to poor health and reduced life span.

How would you rate your posture? Poor 1 2 3 4 5 6 7 8 9 10 Excellent : \_\_\_\_\_

8. Stress causes your spine to misalign and accelerates spinal damage. Rate your stress level over the last 3 months. None 1 2 3 4 5 6 7 8 9 10 Intense : \_\_\_\_\_

9. Please mark any health issues you are experiencing. Mark L/R if worse on one side

Leg pain/numb	L	R	Neck pain	L	R	Heart Disease	Thyroid
Mid-back pain	L	R	Asthma			Cancer	Allergies
Low-back pain	L	R	Headaches/Migraines			Constipation	Other: _____
Arm pain/numb	L	R	Diabetes	I	II	Menstrual pain	_____

10. Though sometimes necessary, prescription medications can cause various side effects, hide the severity of health problems, and hinder the body's ability to heal. What medications are you currently taking?  
\_\_\_\_\_  
\_\_\_\_\_

11. Please list any surgeries (include year) you have had. \_\_\_\_\_  
\_\_\_\_\_

12. Do You Smoke? Yes No

13. (Women Only) Spinal health is vitally important to ensure you and your baby are healthy.

Is there a chance you are pregnant? Yes No

14. Daily trauma, auto accident(s), and work injuries can cause misalignment of vertebrae and serious spinal problems.

When was your most recent injury: At home? \_\_\_\_\_ Car accident? \_\_\_\_\_

Slip or fall? \_\_\_\_\_ Other? \_\_\_\_\_

15. Improper sleeping positions can cause spinal misalignment and spinal damage.

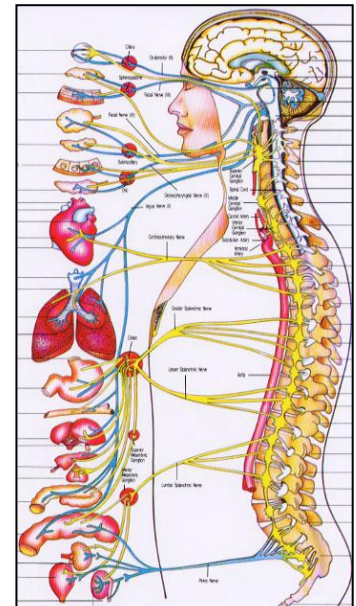
Which sleeping positions do you sleep in: Back Stomach R Side L Side

16. Exercise level: Never 1 2 3 4 5 6 7 8 9 10 Often: \_\_\_\_\_

17. When the spine has misalignments, it can often affect our daily activities. How is it negatively affecting your life? (i.e. difficult to get dressed, can't play a sport, hard to drive a car, can't sleep, requires you to take constant breaks, etc)  
\_\_\_\_\_  
\_\_\_\_\_

18. Please list vitamins/supplements you take: \_\_\_\_\_  
\_\_\_\_\_

19. If the doctor identifies your spine to be misaligned, are you committed to follow the recommendations to correct your problem completely? Yes No



The above information is accurate to the best of my knowledge.

Date: \_\_\_\_\_

Signature (Parent/Guardian if minor)

**Are you currently experiencing any of these symptoms? (Check all the apply)**  
**Many of the following conditions respond to Chiropractic adjustments.**

**General: (constitutional)**

Recent Weight Change  
Fever  
Fatigue  
None in this Category

**Musculoskeletal:**

Low Back Pain  
Mid Back Pain  
Neck Pain  
Arm Problems \_\_\_\_\_  
Leg Problems \_\_\_\_\_  
Painful Joints  
Stiff/Swollen Joints  
Sore/Weak Muscles or Joints  
Muscle Spasms/Cramps  
Broken Bones \_\_\_\_\_  
Other: \_\_\_\_\_  
None in this Category

**Neurological:**

Numbness or tingling sensations  
Loss of Feeling  
Dizziness or light headed  
Frequent or Recurrent Headaches  
Convulsions or seizures  
Tremors  
Stroke  
Have you ever had a head injury?  
Ever been in an auto accident?  
Other: \_\_\_\_\_  
None in this Category

**Mind/Stress:**

Nervousness  
Depression  
Sleep Problems  
Memory Loss or Confusion  
Other: \_\_\_\_\_  
None in this Category

**Genitourinary:**

Sexual Difficulty  
Kidney Stones  
Burning/Painful Urination  
Change in force/strain w Urination  
Frequent Urination  
Blood in Urine  
Incontinence or Bed Wetting  
Other: \_\_\_\_\_  
None in this Category

**Gastrointestinal:**

Loss of Appetite  
Blood in Stool  
Change in Bowel Movements  
Painful Bowel Movements  
Nausea or Vomiting  
Abdominal Pain  
Frequent Diarrhea  
Constipation  
Other: \_\_\_\_\_  
None in this Category

**Cardiovascular & Heart:**

Chest Pains  
Rapid or Heartbeat changes  
Blood Pressure Problems  
Swelling of Hands, Ankles, or Feet  
Heart Problems  
Other: \_\_\_\_\_  
None in this Category

**Respiratory:**

Difficulty Breathing  
Persistent Cough  
Coughing Blood  
Asthma or Wheezing  
Lung Problems  
Other: \_\_\_\_\_  
None in this Category

**Eyes and Vision:**

Wear contacts/glasses  
Blurred or double vision  
Glaucoma  
Eye disease or injury  
Other: \_\_\_\_\_  
None in this Category

**Ears, Nose and Throat:**

Bleeding gums / mouth sores  
Bad Breath or bad taste  
Dental Problems  
Swollen throat or voice change  
Swollen glands in neck  
Ear - Ache/Ringing/Drainage  
Sinus / Allergy problems  
Nose Bleeds  
Hearing Loss  
Other: \_\_\_\_\_  
None in this Category

**Endocrine, Hematologic, and Lymphatic:**

Thyroid problems  
Diabetes  
Excessive Thirst or urination  
Cold Extremities  
Heat or Cold intolerance  
Change in hat or glove size  
Dry skin  
Glandular or hormone problem  
Swollen Glands  
Anemia  
Easily Bruise or Bleed  
Phlebitis  
Transfusion  
Immune system disorder  
Other: \_\_\_\_\_  
None in this Category

**Skin and Breasts:**

Rash or Itching  
Change in Skin Color  
Change in hair or nails  
Non-healing sores  
Change of appearance of a mole  
Breast Pain  
Breast Lump  
Breast Discharge  
Other: \_\_\_\_\_  
None in this Category

**Women Only:**

**Are you pregnant?**

**Yes - Due Date** \_\_\_/\_\_\_/\_\_\_

**No - Last Menstrual** \_\_\_/\_\_\_/\_\_\_

Infertility  
Painful or Irregular periods  
Vaginal Discharge  
Other: \_\_\_\_\_  
None in this Category

**Pregnancies with Outcome & Date:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Comments:** \_\_\_\_\_

*I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.*

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Treating Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_